

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS419AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2009
NAME OF PROVIDER OR SUPPLIER THE SALVN. ARMY PATHWAYS PROG.		STREET ADDRESS, CITY, STATE, ZIP CODE 37 WEST OWENS N LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 6/3/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for forty-two (42) Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 37. Fifteen resident files were reviewed and 10 employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D.</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 103 SS=F	<p>449.200(1)(d) Personnel File - NAC 441A</p> <p>NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.</p> <p>This Regulation is not met as evidenced by: Based on record review on 6/3/09, the facility</p>	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS419AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2009
NAME OF PROVIDER OR SUPPLIER THE SALVN. ARMY PATHWAYS PROG.		STREET ADDRESS, CITY, STATE, ZIP CODE 37 WEST OWENS N LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 1 failed to ensure 2 of 10 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #8 and #10) for the protection of 37 of 37 residents Severity: 2 Scope: 3	Y 103		
Y 172 SS=C	449.209(2) Health and Sanitation-Outside garbage NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. This Regulation is not met as evidenced by: Based on observation on 6/3/09, the facility failed to ensure the containers used to store garbage outside the facility was covered. This is attracts rodents. Severity: 1 Scope: 3	Y 172		
Y 178 SS=C	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.	Y 178		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS419AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2009
NAME OF PROVIDER OR SUPPLIER THE SALVN. ARMY PATHWAYS PROG.		STREET ADDRESS, CITY, STATE, ZIP CODE 37 WEST OWENS N LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 178	Continued From page 2 This Regulation is not met as evidenced by: Based on observations on 6/3/09, the administrator failed to ensure the exterior doors to the patio areas of both the men's and the ladies' sides of the building allowing access by rodents. Severity: 1 Scope: 3	Y 178		
Y 255 SS=F	449.217(6)(a)(b) Permits - Comply with NAC 446 NAC 449.217 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division. This Regulation is not met as evidenced by: Based on observations, interview, and record review on 6/3/09, the facility failed to comply with the provisions of NAC 446. Findings include: Sanitation and food safety deficiencies were identified in the Lied Kitchen, which is the source of the food being served to the residents.	Y 255		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS419AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2009
NAME OF PROVIDER OR SUPPLIER THE SALVN. ARMY PATHWAYS PROG.		STREET ADDRESS, CITY, STATE, ZIP CODE 37 WEST OWENS N LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 255	Continued From page 3 There was no sanitizer test kit available for checking the concentration of sanitizer that was used to wipe the kitchen counters and the dining room tables. There were unlabeled spray bottles of cleaning product in the kitchen and the janitor room. There were two household microwaves and one household refrigerator-freezer in the kitchen used for residents' food. There were no paper towels in the staff men's room. The walls were soiled in the staff men's room. There were uncovered waste receptacles in the staff men's and ladies restrooms. The person-in-charge did not receive food safety certification. Severity 2, Scope 3	Y 255		
Y 304 SS=E	449.218(4) Bedrooms - Privacy NAC 449.118 4. The arrangement of the beds and other furniture in the bedroom must provide privacy for and promote the safety of the residents occupying the bedroom. Adjustable curtains, shades, blinds or similar devices must be provided for visual privacy.	Y 304		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS419AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2009
NAME OF PROVIDER OR SUPPLIER THE SALVN. ARMY PATHWAYS PROG.		STREET ADDRESS, CITY, STATE, ZIP CODE 37 WEST OWENS N LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 304	Continued From page 4 This Regulation is not met as evidenced by: Based on observations on 6/3/09, the facility failed to ensure privacy for 12 of 42 client bedrooms in the facility (Room #1, #2, #3, and #4). Severity: 2 Scope: 2	Y 304		
Y 444 SS=F	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility. This Regulation is not met as evidenced by: Based on record review on 6/3/09, the facility failed to ensure smoke detectors were tested 11 out of the past 12 months (June, July, August, September, October, November and December of 2008, and January, February, March, and April of 2009). Severity: 2 Scope: 3	Y 444		
Y 882 SS=D	449.2742(6)(c) Medication / change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be	Y 882		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS419AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2009
NAME OF PROVIDER OR SUPPLIER THE SALVN. ARMY PATHWAYS PROG.		STREET ADDRESS, CITY, STATE, ZIP CODE 37 WEST OWENS N LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 882	Continued From page 5 administered to a resident: (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. This Regulation is not met as evidenced by: Based on record review on 6/3/09, the facility failed to ensure medication labels matched physician orders for 1 of 15 residents (Residents #4). Severity: 2 Scope: 1	Y 882		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.	Y 936		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS419AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2009
NAME OF PROVIDER OR SUPPLIER THE SALVN. ARMY PATHWAYS PROG.		STREET ADDRESS, CITY, STATE, ZIP CODE 37 WEST OWENS N LAS VEGAS, NV 89030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 6 This Regulation is not met as evidenced by: Based on record review on 6/3/09, the facility failed to ensure X of X residents complied with NAC 441A.380 regarding tuberculosis (Resident #2, #7, #9 and #12) which affected all residents. Severity: 2 Scope: 3	Y 936		
Y1010 SS=D	449.2764(1) MI Training NAC 449.2764 1. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after he becomes employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. This Regulation is not met as evidenced by: Based on record review on 6/3/09, the facility failed to ensure not less than 8 hours of training concerning care for residents who are suffering from mental illnesses for 2 of 10 employees (Employee #3 and #6). Scope: 2 Severity: 1	Y1010		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.